



Kentucky Safety Program
Supervisor's Accident Investigation Report

Section I: Employee Information

Employee: _____ Job Title: _____
Cabinet: _____ Department: _____
Division / Facility / Location: _____
Length of Employment: ☐ Less than 1 mo. ☐ 1-6 mos. ☐ 6 mos.-5 yrs ☐ Over 5 yrs.
Time in Current Job: ☐ Less than 1 mo. ☐ 1-6 mos. ☐ 6 mos.-5 yrs ☐ Over 5 yrs.

Section II: Accident Description

Include Date/Time of occurrence, describe what happened, Task being performed, Object(s) involved.
PLEASE BE SPECIFIC:

Section III: Injury Information

<input type="checkbox"/> Abrasion	<input type="checkbox"/> Contusion	<input type="checkbox"/> Laceration	<input type="checkbox"/> Puncture	<input type="checkbox"/> Heat	<input type="checkbox"/> Avulsion
<input type="checkbox"/> Burn	<input type="checkbox"/> Dermatitis	<input type="checkbox"/> Foreign Body	<input type="checkbox"/> Fracture	<input type="checkbox"/> Cold	<input type="checkbox"/> Radiation
<input type="checkbox"/> Inhalation	<input type="checkbox"/> Absorption	<input type="checkbox"/> Ingestion	<input type="checkbox"/> Injection	<input type="checkbox"/> Sprain	<input type="checkbox"/> Strain
<input type="checkbox"/> Loss of Consciousness		<input type="checkbox"/> Cumulative Trauma Disorder		<input type="checkbox"/> Other: _____	

Section IV: Severity

☐ None ☐ Fatality ☐ Lost Time ☐ Restricted Activity/Duty ☐ Job Transfer

Section V: Body Parts

<input type="checkbox"/> Head	<input type="checkbox"/> Face	<input type="checkbox"/> Neck	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Toe	<input type="checkbox"/> Eye	<input type="checkbox"/> Back
<input type="checkbox"/> Leg	<input type="checkbox"/> Knee	<input type="checkbox"/> Ankle	<input type="checkbox"/> Foot	<input type="checkbox"/> Chest	<input type="checkbox"/> Ear	<input type="checkbox"/> Arm
<input type="checkbox"/> Hand	<input type="checkbox"/> Finger	<input type="checkbox"/> Other: _____	Describe: _____			

Section VI: Treatment / Action Taken

☐ None ☐ First Aid Only ☐ Personal Physician ☐ Emergency Room ☐ Admission
☐ Medical Monitoring Only ☐ Other: (Describe) _____

Section VII: Causal Factors

<input type="checkbox"/> Combative Person	<input type="checkbox"/> Improper Guarding	<input type="checkbox"/> Inadequate Lighting	<input type="checkbox"/> Hazardous Storage
<input type="checkbox"/> Defective Equipment	<input type="checkbox"/> Inadequate Ventilation	<input type="checkbox"/> Contact w/ Irritants	<input type="checkbox"/> Hazardous Weather
<input type="checkbox"/> Distraction by Others	<input type="checkbox"/> Inadequate Warning	<input type="checkbox"/> Unsafe Surface	<input type="checkbox"/> Faulty Safety Equip.
<input type="checkbox"/> Faulty / Poor Design	<input type="checkbox"/> PPE Not Used	<input type="checkbox"/> Contact w/ Toxin	<input type="checkbox"/> Unsecured Equip.
<input type="checkbox"/> Hazardous Procedures	<input type="checkbox"/> Insect/Animal Attack	<input type="checkbox"/> Poor Housekeeping	<input type="checkbox"/> Unsafe Procedures
<input type="checkbox"/> Unauthorized Use	<input type="checkbox"/> Wrong Tool Used	<input type="checkbox"/> Inhaled Toxin	<input type="checkbox"/> Unsafe Speed
<input type="checkbox"/> Insufficient Training	<input type="checkbox"/> Improper Apparel	<input type="checkbox"/> Unsafe Position	<input type="checkbox"/> Unsafe Posture
<input type="checkbox"/> Defeated Safety Equip.	<input type="checkbox"/> Failure to Observe Rules / Regulations		
<input type="checkbox"/> Investigation Reveals Accident was Beyond Employee Control		<input type="checkbox"/> Other: _____	

Section VIII: Action(s) Taken to Prevent Recurrence

Supervisor _____

Title: _____

Date _____